

# REQUEST TO ADD COMMERCIAL INSURANCE INFORMATION FOR HEALTH PLAN MEMBERS

Michigan Department of Community Health

## INSTRUCTIONS:

- Complete this form and send to:  
**REVENUE AND REIMBURSEMENT DIVISION  
BUREAU OF FISCAL REVIEW AND REIMBURSEMENT  
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH  
PO BOX 30435  
LANSING MI 48909**
- FAX: **(517) 335-8868**
- EMAIL: **TPL@Michigan.Gov**
- If you have questions or comments, please call **(517) 335-9726**.
- This form and other information are also available through the internet at:  
**MDCH.State.MI.US/Msa/Mdch\_Msa/Third\_Party\_Liability**

Health Plan Name	Date
Contact Person Name	Contact Person's Phone Number
Customer / Beneficiary Name	
Customer / Medicaid I.D. Number	
Commercial Insurance Name	Commercial Insurance Phone Number
Commercial Insurance COMPLETE ADDRESS (No. & Street, Suite No., City, State, ZIP Code)	
Type of Coverage: (use an "X") <input type="checkbox"/> <b>Traditional</b> <input type="checkbox"/> <b>Managed Care</b> (Preferred Provider Organization, Health Maintenance Organization, Point of Service)	
Name of Pharmacy Benefit Manager (if utilized)	Phone Number (if available)
Policyholder Name	
Policyholder Social Security Number / Contract Number	
Policy / Group Number (If Different than Social Security Number)	Effective Date of Commercial Coverage
Employer Name (if known)	
Additional Comments (include covered dependents and their Medicaid ID Number):	

**AUTHORITY:** Title XIX of the Social Security Act  
**COMPLETION:** Is VOLUNTARY, but is required if Medical Assistance program payment is desired.

The Department of Community Health is an equal opportunity employer, services, and programs provider.